DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 7471 (07/03)

STATE OF WISCONSIN
Chapter 110, Wis. Admin. Code
(608) 266-1568

EMERGENCY MEDICAL TECHNICIAN VERIFICATION OF LICENSURE

This form is authorized under s. 146.50, Wis. Stats ., and Chapter 110, Wis. Admin. Code. Completion of this form is mandatory for licensure as an EMT by reciprocity. Personally identifiable information requested on this form will only be used for licensure purposes. Provision of your social security number is optional and is used by the Bureau of EMS and Injury Prevention only as an identifier in the licensure database.

INSTRUCTIONS: Type or print legibly. Complete Section A of this form; send a copy to all states where you have been granted a license as an EMT.

SECTION A: APPLICANT INFORMATION

Last Name	First Name	MI	Former Name(s)

Mailing Address

City	State	Zip Code	Date of Birth	Social Security Number(Optional)

Daytime Telephone Number	Other Telephone Number

SECTION B: TO BE COMPLETED BY STATE LICENSING AGENCY

The above-named individual has applied for a Wisconsin EMT license based upon reciprocity from your state. Complete Section B of this form and forward to the Wisconsin Department of Health and Family Service.

State Verifying License	License Number

This applicant is/was certified/licensed/registered in your state as:	Issue Date	Expiration Date
☐ First Responder		
☐ EMT-Basic		
☐ EMT-Intermediate (1985 curriculum) or ☐ EMT-Intermediate (1999 curriculum)		
☐ EMT-Paramedic (1986 curriculum) or ☐ EMT-Paramedic (1999 curriculum)		
☐ Other:		

Date of last DOT-approved refresher training:

☐ Yes ☐ No Has this applicant's EMT license ever been denied, reprimanded, limited, suspended or revoked?

If yes, please provide a copy of the disciplinary action.

☐ Yes ☐ No Is there any reason this applicant should not be licensed in Wisconsin?

If yes, please explain:

SECTION C: STATE LICENSING AGENCY CERTIFICATION

Print name of person completing this form	Title	
SIGNATURE	Date	Telephone Number

Mail or FAX completed form to:

DEPARTMENT OF HEALTH AND FAMILY SERVICES
BUREAU OF EMS AND INJURY PREVENTION
LICENSING MANAGER
PO BOX 2659
MADISON WI 53701-2659
FAX: 608-261-6392